



MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-11.0	Subject: Completing Nursing Protocols
Reference: NCCHC Standard P-E-11, 2008	Page 1 of 3 and no attachments
Effective Date: November 1, 2010	Revised: June 1, 2017
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I. Purpose:

To define the procedure to be used by all nursing staff in completing nursing protocols.

II. Definitions: none

III. Procedure:

- A. All nurses who assess patients based upon submission of a health care request are to complete a nursing protocol based on the assessment.
 - 1. Assessments are essential in providing continuity of care and help ensure nursing staff gather enough data to support their nursing plan.
 - 2. The importance of using the protocol at the visit cannot be overemphasized (a poorly documented record could indicate that the nurse did not see the patient or did not have the protocol at the visit and completed it at a later time and/or date).
- B. Steps:
 - 1. Choose the protocol based on the chief complaint, not a diagnosis. All protocols need to be completely filled out and will include the following:
 - a. Patient data: include name, ID/AO number, age, allergies, and current meds. If the patient cannot list his meds, it is acceptable to state “see current MAR.”
 - b. Subjective: enter any information the patient gives you. If they say it, document it. If the patient is too unstable to give a complete history, indicate the reason why (e.g. “Subjective data limited by clinical condition-decreased LOC”).
 - c. Objective: enter your observations. If you see it, document it. Use blank lines to record pertinent information to patient’s care. The protocol is not intended to replace your clinical judgment. If it isn’t on the protocol it doesn’t mean you can’t add it.
 - d. Assessment Decision: check the choice for referral. If subjective and objective data support referral be sure it is requested. If you think a referral is not appropriate, yet the protocol states referral required, document a consult with the Infirmary RN or a provider, and determine why a referral is not being made.
 - e. Plan: protocols are standing orders. Protocols allow the nurse to follow the orders just as if written by a provider. If something is not included in the plan (certain meds, treatments, etc) do not initiate unless consulting with the provider. If approved, write a verbal order on the protocol, just as you would on an order sheet, and sign it as such.
 - f. Nurse’s Signature and date.
 - 2. Marking the protocols.
 - a. Circle positive items or place a check mark in the box associated with item. It is best to circle items that you want the reader to note, such as all positives or

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abnormals. The reader can thereby rapidly grasp the “story of the case” by following circled items.

☐ vomiting _____ or ☒ vomiting _____

- b. Back-slash negative items – mark from 10 to 4 o’clock through the body of the word.

☐ vomiting _____ = no vomiting”

NOT THIS:

☐ vomiting _____ = the forward slash could be confused with a check mark

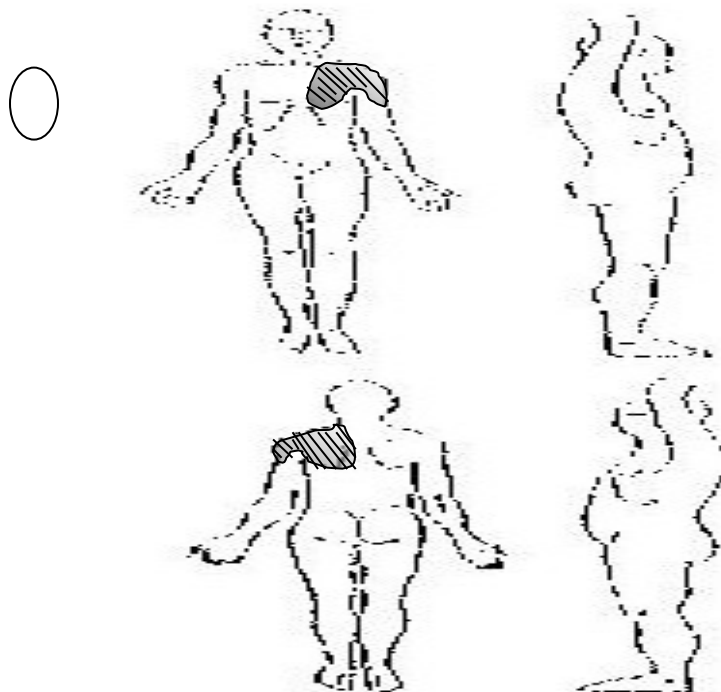
☐ vomiting _____ = put the backslash through the body of the work to avoid confusion

☐ vomiting _____

☐ nausea _____

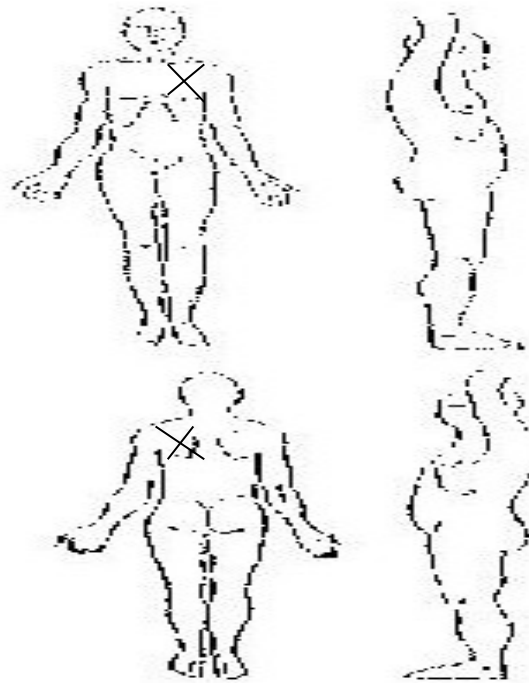
☐ abdominal pain _____ = slashing several at a time suggests that questions were not asked separately – slash each separately.

- c. Shade areas to mark locations on a diagram of importance. Do not place an X over areas; rather draw a circle around the area of relevance and cross hatch to fill in.



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Not This:



3. Be prepared to jump to different areas of the protocol during the assessment. The patient may not follow the same order as the protocol does.
4. Upon completing the protocol, attach it to the medical kite. Be sure to sign and date the kite as well as the protocol.

C. Review:

1. The nurse who completed the medical kite and protocol will place it in the “scheduled to be seen” mailing basket (the same basket medical kites are placed).
2. A supervisor will periodically review the kites and protocols to assess the protocol’s completeness.
3. If the supervisor finds inconsistencies, incompleteness, inappropriateness, or any other issue, he/she will talk to the nurse who completed the protocol as soon as possible to correct the problem.

IV. Closing

Questions concerning this operational procedure will be directed to the Health Services Manager.

V. Attachments

None